U.S. Department of Labor

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Issue Date: 23 February 2006

In the Matter of:

LOVELLA LEONARD, on behalf of
CHARLES L. LEONARD, deceased
Claimant,

v. **Case No.: 2004-BLA-05806**

UNITED STATES STEEL CORP.,
Self-Insured Employer, and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

Frederick Muth, Esq., Hensley, Muth, Garton & Hayes, Bluefield, WV
For Claimant

Harold Salisbury, Esq., Kay, Casto & Chaney, PLLC, Charleston, WV
For Employer and Carrier

Before: PAMELA LAKES WOOD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a subsequent or duplicate claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901, *et. seq.* (hereafter "the Act") filed by Miner Charles L. Leonard ("Claimant") on July 1, 2002. The putative responsible operator is United States Steel Corporation ("Employer"), which is self insured. Payments have been made to the Claimant from the Trust Fund. Following the March 30, 2005 hearing in this matter, on June 19, 2005, the Claimant died and his counsel indicated that he was authorized to continue representation in this matter by the Claimant's widow, Lovella Leonard. The caption has been amended to reflect that this claim is now being pursued on the Claimant's behalf by his widow. Our sympathy goes out to Mrs. Leonard on her loss.

Part 718 of title 20 of the Code of Federal Regulations is applicable to this claim, as it was filed after March 31, 1980. 20 C.F.R. §718.2. [1] In *National Mining Assn. v. Dept. of Labor,* 292 F.3d 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit rejected the challenge to, and upheld, the amended regulations with the exception of several sections.[2] The Department of Labor amended the regulations on December 15, 2003, solely for the purposes of complying with the Court's ruling. 68 Fed. Reg. 69929 (Dec. 15, 2003).

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all evidence admitted and arguments submitted by the parties. Where pertinent, I have made credibility determinations concerning the evidence.

STATEMENT OF THE CASE

Claimant filed his first claim for benefits on January 14, 1987. (DX 1).[3] In the claim form, he indicated that he was born in February 1930, he worked 38 years in coal mining, and he stopped working in the coal mines in August 1986, when the mines closed down. *Id.* The Department of Labor examination was performed by Dr. M. I. Ranavaya on February 13, 1987. *Id.* The claim was denied by a claims examiner on July 6, 1987 because the evidence did not show that the Claimant had pneumoconiosis, that the disease was caused at least in part by coal mine work, or that he was totally disabled by the disease. *Id.* No appeal was filed and the denial became final.

The instant claim was filed on July 1, 2002. (DX 3). On October 9, 2002, Dr. J. Randolph Forehand examined the Claimant on behalf of the Department of Labor. (DX 13). On July 31, 2003, a Claims Examiner issued a Schedule for the Submission of Additional Evidence, which stated that based upon the evidence of record developed so far, it was determined that the Claimant would be entitled to benefits if a decision were issued at that time and that U. S. Steel Corporation, self-insured thru U.S. Steel Corporation, was the responsible operator liable for the payment of benefits. (DX 17). The Employer contested the Claimant's entitlement to benefits. (DX 19). A "Proposed Decision and Order, Award of Benefits—Responsible Operator" was issued by the District Director on or about January 16, 2004. (DX 28). The district director determined that the evidence showed that the Claimant was employed for 37 years in coal mining, from November 20, 1948 until August 28, 1986; that as a result of the conditions of his coal mine employment, he contracted pneumoconiosis; that such disease caused a breathing impairment of sufficient degree to establish total disability; and that U.S. Steel Corporation was the coal mine operator designated as responsible for payment of benefits due to the Claimant. (DX 20). Employer, through counsel, objected to the proposed decision and requested a formal hearing. (DX 21). Benefits were initiated by the Trust Fund effective July 2002 with two augmentees. (DX 23). The case was transmitted for a hearing on February 25, 2004. (DX 24).

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[1] Section and part references appearing herein are to Title 20 of the Code of Federal Regulations unless otherwise indicated.

[2] Several sections were found to be impermissibly retroactive and one which attempted to effect an unauthorized cost shifting was not upheld by the court.

[3] Director's Exhibits, Claimant's Exhibits, Employer's Exhibits, and Administrative Law Judge Exhibits will be referenced as "DX", "CX", "EX", and "ALJ", respectively, followed by the exhibit number. References to the hearing transcript appear as "Tr." followed by the page number.

Pursuant to a Notice of Hearing and Prehearing Order of December 8, 2004, a hearing was noticed and held before the undersigned administrative law judge on March 30, 2005 in Princeton, West Virginia. At the hearing, Director's Exhibits 1 through 26 (DX 1 through DX 26), Claimant's Exhibit 1, and Employer's Exhibits 1, 2, and 3 were admitted into evidence.[4] Employer's Exhibit 4, consisting of an October 9, 2002 x-ray interpretation by Dr. Carl B. Binns, was rejected as exceeding the evidentiary limitations. (Tr. 22-24). Both the Employer and the Claimant filed prehearing reports and evidence designations/summaries. The record was not kept open for any purpose but the parties were allowed until May 18, 2005 for the submission of any briefs or written closing arguments, which period could be extended for 30 days by stipulation.

The Claimant's Brief was served on May 13, 2005 and filed on May 17, 2005 and Employer's letter brief was served on May 18, 2005 and filed on May 23, 2005. Both briefs are accepted as timely filed.

By letters of June 22, 2005 and August 2, 2005, counsel for the Claimant advised that his client passed away on June 19, 2005. He submitted a copy of the death certificate and a Form CM-1078 executed by the Claimant's widow, Lovella Leonard. The Claimant's widow, Lovella Leonard, is hereby substituted for the Claimant in this matter, to pursue the claim for benefits that he filed during his lifetime on his behalf. **SO ORDERED.**

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Issues/Stipulations

The following matters are currently at issue (DX 24, Tr. 6-7):

1. Existence of Pneumoconiosis;

2. Causal Relationship with Coal Mine Employment;

3. Total Disability; and

4. Disability Causation.

(DX 34; Tr. 5-7.) The parties stipulated to 36 years of coal mine employment and the existence of one dependent (the Claimant's wife) for augmentation purposes, and an additional dependent (the Claimant's daughter) during the period that she was a student. (Tr. 6-7). The issue of Responsible Operator is not contested. (Tr. 7).

[4] CX 1 was Dr. Rasmussen's September 22, 2004 examination report, associated testing results, and x-ray reading by Dr. Patel; EX 1 was the October 18, 2004 examination report by Dr. George L. Zaldivar, with associated testing results, his x-ray reading and CT scan reading, another CT scan reading, and his c.v.; EX 2 was the April 20, 2004 examination report by Dr. Kirk E. Hippensteel with associated testing results and his c.v.; and EX 3 was the x-ray interpretation of an October 9, 2002 x-ray by Dr. R.K. Gogineni and his c.v.

Because this is a duplicate or subsequent claim, there technically is a threshold issue of whether the Claimant has established a basis for reopening the claim under 20 C.F.R. §725.309, as amended. That issue was not listed by the Director. However, as the Claimant's total respiratory disability is clearly established by the evidence before me, the Claimant can establish an element upon which the claim was previously denied and the district director's failure to list that issue is of no practical significance. This matter is addressed more fully below.

Background and Employment History

Claimant testified at the hearing before me. He was on oxygen at the time of the hearing and had to use his inhaler before he testified. He stated that he was born in February 1930 and was 75 years old at the time of the hearing. (Tr. 9). He testified that he was married, and his wife was dependent upon him and living with him, and he had a daughter, Stephanie, who had attended the University in Beckley and was a dependent student until May 2004 (Tr. 10). His educational background included one year of college. *Id.* He was also trained as a mechanic pumper for mine work. (Tr. 11). At the time of the hearing, he was 5 feet 7 inches tall and weighed 120 pounds. *Id.* His current sources of income were Social Security and a pension from the UMW (United Mine Workers). *Id.* In the early 1980's, Claimant received benefits from the state of West Virginia for a rock dust claim, based upon a 15 percent disability rating. (Tr. 12).

Claimant estimated that he worked 38 years in the mining industry. (Tr. 12). His employer during the entire period was U.S. Steel and he worked as a mechanic pumper above ground (Tr. 12). In that capacity, he worked on a pump that supplies the water and oil to the plant and he worked at the plant. (Tr. 13). Heavy exertion was required, as was heavy lifting. (Tr. 13-14). He would be involved if a pump or crankshaft would break down, and he would have to change the crankshaft, put in backup bearings, or fix the lines if they burst. (Tr. 13). He last worked there in August 1986, when they closed the plant down. (Tr. 12-13). After August 1986, he did not work for any other coal mining company. (Tr. 13). The reason that he did not look for other work was that he "couldn't breathe too well." (Tr. 14).

Claimant testified that he was being treated for his breathing problems by Dr. Agarwal and that he had been seeing Dr. Agarwal for approximately three or four years. (DX 14). Dr. Agarwal is the physician who has prescribed all of his medicines as well as his oxygen. (Tr. 14-15). He was using two liters of oxygen per day, plus a home nebulizer and oxygen machine. (Tr. 15). He was hospitalized by Dr. Agarwal for his breathing on multiple occasions, at the University of Virginia and Bluefield Hospital. *Id.* He was scheduled to have an operation at the University of Virginia but was told they were unable to operate because it would kill him. (Tr. 17). He was last hospitalized in February 2004. *Id.* Claimant stated that he did not think that he could go back to work with his breathing problem. (Tr. 16). He was unaware of any medical problems apart from his breathing.[5] (Tr. 17).

On cross examination, Claimant admitted to having been a cigarette smoker until he stopped when he was in his late twenties. (Tr. 16). On redirect, he admitted to having smoked for a longer period and to having told Dr. Rasmussen that he started smoking at age 16 in 1946

[5] The medical reports indicate that Claimant also gave a history of cardiac problems to the examining physicians.

and smoked a half pack daily until he quit in 1970; however, he characterized it as "sneaking around" and said that it was less than one half pack daily, which was just an estimate he made. (Tr. 19-20). He disagreed with the doctors who said he smoked one half pack of cigarettes for 30 years. (Tr. 20).

After he left U.S. Steel in 1986, he was employed as a City Judge but he said, "I didn't work, I just sit." (Tr. 17). He could not recall the dates that he was so employed. *Id.* However, the mayor, who had been the City Judge, asked him if he would go to Charleston for the training, and Claimant worked with him for about eight or nine years. (Tr. 18). He had to quit about two or three years before the time of the hearing because he would get "out of wind," but he was still periodically consulted about ordinances. (Tr. 18-19).

Discussion and Analysis

The Black Lung Benefits Act provides benefits to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis. 20 C.F.R. §718.1(a). In addition to establishing the existence of pneumoconiosis, unless complicated pneumoconiosis can be shown, a claimant must prove that (1) the pneumoconiosis arose out of coal mine employment; (2) he or she is totally disabled, as defined in section 718.204; and (3) the total disability is due to pneumoconiosis. 20 C.F.R. §§718.202 to 718.204. The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. In *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994), the Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants. Thus, in order to prevail in a black lung case, the claimant must establish each element by a preponderance of the evidence.

Evidentiary Limitations

My consideration of the medical evidence is limited under the regulations, which apply evidentiary limitations to all claims filed after January 19, 2001. 20 C.F.R. §725.414. Section 725.414, in conjunction with Section 725.456(b)(1), sets limits on the amount of specific types of medical evidence that the parties can submit into the record. *Dempsey v. Sewell Coal Co.*, 21 BLR --, BRB No. 03-0615 BLA (June 28, 2004) (en banc) (slip op. at 3), *citing* 20 C.F.R. §§725.414; 725.456(b)(1). Under section 725.414, the claimant and the responsible operator may each "submit, in support of its affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports." *Id., citing* 20 C.F.R. §725.414(a)(2)(i),(a)(3)(i). In rebuttal of the case presented by the opposing party, each party may submit "no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by" the opposing party "and by the Director pursuant to §725.406." *Id., citing* 20 C.F.R. §725.414(a)(2)(ii), (a)(3)(ii). Following rebuttal, each party may submit "an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing," and, where a medical report is undermined by rebuttal evidence, "an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence." *Id.*

"Notwithstanding the limitations" of section 725.414(a)(2),(a)(3), "any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence." *Id., citing* 20 C.F.R. §725.414(a)(4). Medical evidence that exceeds the limitations of Section 725.414 "shall not be admitted into the hearing record in the absence of good cause." *Id.*, *citing* 20 C.F.R. §725.456(b)(1). The parties cannot waive the evidentiary limitations, which are mandatory and therefore not subject to waiver. *Phillips v. Westmoreland Coal Co.*, 2002-BLA-05289, BRB No. 04-0379 BLA (BRB Jan. 27, 2005) (unpub.) (slip op. at 6).

Evidence from prior federal black lung claims is automatically admissible under 20 C.F.R. §725.309(d)(1).

The Benefits Review Board discussed the operation of these limitations in its en banc decision in *Dempsey, supra*. First, the Board found that it was error to exclude CT scan evidence because it was not covered by the evidentiary limitations and instead could be considered "other medical evidence." *Dempsey* at 5; *see* 20 C.F.R. § 718.107(a) (allowing consideration of medical evidence not specifically addressed by the regulations). Further, the Board found that it was error to exclude pulmonary function tests and arterial blood gases derived from a claimant's medical records simply because they had been proffered for the purpose of exceeding the evidentiary limitations. *Dempsey* at 5. However, the Board found that records from a state claim were properly excluded as they did not fall within the exception for hospitalization or treatment records or the exception for prior federal black lung claim evidence (under 20 C.F.R. §725.309(d)(1)). *Dempsey* at 6. On the issue of good cause for waiver of the regulations, the Board noted that a finding of relevancy would not constitute good cause and therefore records in excess of the limitations offered on that basis, and on the basis that the excluded evidence would be "helpful and necessary" for the reviewing physicians to make an accurate diagnosis, were properly excluded. *Id.* at 6. Finally, the Board stated that inasmuch as the regulations do not specify what is to be done with a medical report that references inadmissible evidence, it was not an abuse of discretion to decline to consider an opinion that was "inextricably intertwined" with excluded evidence. *Id.* at 9. Referencing *Peabody Coal Co. v. Durbin*, 165 F.3d 1126, 21 BLR 2-538 (7th Cir. 1999), the Board acknowledged that it was adopting a rule contrary to the common law rule allowing inadmissible evidence to be considered by a medical expert, because "[t]he revised regulations limit the scope of expert testimony to admissible evidence." *Dempsey* at 9-11.

In *Webber v. Peabody Coal Co,* 23 B.L.R. 1-__, BRB No. 05-0335 BLA (Jan. 27, 2006)(en banc), the Board changed the position that it took in *Dempsey* with respect to CT scan evidence and adopted the Director's position that "the use of singular phrasing in 20 C.F.R. § 718.107" requires "only one reading or interpretation of each CT scan or other medical test or procedure to be submitted as affirmative evidence."

In this case, the record is in compliance with the evidentiary limitations, with the exception of the second tendered rebuttal x-ray reading (EX 4), which has been excluded from consideration.

Subsequent Claims Analysis

As this is the second claim filed by the Claimant, the instant claim is a duplicate or subsequent claim. Previously, such a claim would be denied based upon the prior denial unless the claimant could establish a material change in conditions. *See* 20 C.F.R. §725.309(d). The standard for finding a "material change in conditions" is governed by the Fourth Circuit's holding in *Lisa Lee Mines v. Director, OWCP,* 86 F.3d 1358 (4th Cir. 1996) (en banc). In *Lisa Lee Mines*, the Court adopted the Director's one-element standard, "which requires the claimant to prove, under all of the probative medical evidence of his condition after the prior denial, at least one of the elements previously adjudicated against him." *See also Allen v. Mead Corp.*, 22 B.L.R. 1-61 (2000); *Caudill v. Arch of Kentucky, Inc.*, 22 B.L.R. 1-97 (2000) (en banc on recon.) However, evidence in existence at the time the first claim was decided may not establish a material change. *See Cline v. Westmoreland Coal Co.*, 21 B.L.R. 1-69 (1997).

The amended regulations have replaced the material-change-in-conditions standard with the following, essentially similar standard:

> (d) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see §725.502(a)(2)), the later claim shall be considered a subsequent claim for benefits. **A subsequent claim** shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim **shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement** (see §§725.202(d) (miner), 725.212 (spouse), 725.218 (child), and 725.222 (parent, brother, or sister)) **has changed since the date upon which the order denying the prior claim became final.**[6] The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:
> (1) Any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
> (2) For purposes of this section, **the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based.** For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.
> (3) **If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence**

[6] For a miner, the conditions of entitlement include whether the individual (1) is a miner as defined in the section; (2) has met the requirements for entitlement to benefits by establishing pneumoconiosis, its causal relationship to coal mine employment, total disability, and contribution by the pneumoconiosis to the total disability; and (3) has filed a claim for benefits in accordance with this part. 20 C.F.R. §725.202(d) *Conditions of entitlement: miner.*

> **submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement.** . .
> (4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see § 725.463), shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim. . . .[Emphasis added.]

20 C.F.R. § 725.309(d) (2001).

The previous claim was denied because the Claimant failed to establish any of the medical elements of entitlement. Thus, in order to satisfy the regulatory criteria, the Claimant must establish either that he suffers from pneumoconiosis, that the disease was caused at least in part by coal mine employment, that he is totally disabled, or that the total disability was due to pneumoconiosis, based upon the newly submitted evidence.

As noted above, "Subsequent Claims" was not marked as a disputed issue. However, that omission is of no practical significance as it is apparent that the Claimant was totally disabled from a pulmonary or respiratory standpoint before he died based upon the pulmonary function studies, arterial blood gases, and medical opinions. As Claimant can clearly establish one of the elements of entitlement upon which the previous claim was denied, this claim may not be denied on the basis of the previous denial Accordingly, I will proceed to consideration of the merits of the claim.

Existence of Pneumoconiosis

In reviewing the evidence on the issue of pneumoconiosis, I must take into consideration the fact that it is the Claimant's burden of proof on that issue as with all others.

"Pneumoconiosis," commonly known as "black lung disease," is defined as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. §718.201(a) (2001). The definition has been modified to expressly include "both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal' pneumoconiosis." *Id.* Clinical pneumoconiosis consists of conditions, such as coal workers' pneumoconiosis or silicosis, that the medical community recognizes as pneumoconioses, "*i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment." *Id.* at (a)(1). The regulations define legal pneumoconiosis as "any chronic lung disease or impairment and its sequelae arising out of coal mine employment" and explain that "[t]his definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." *Id.* at (a)(2). The section continues by stating that "'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." *Id.* at §718.201(b). Thus, a claimant miner who cannot prove clinical pneumoconiosis may prove the

existence of legal pneumoconiosis if he or she can show that his or her lung condition was substantially aggravated by coal mine employment.

The regulations (in section 718.202(a)) provide several means of establishing the existence of pneumoconiosis: (1) a chest x-ray meeting criteria set forth in 20 C.F.R. §718.102, and in the event of conflicting x-ray reports, consideration is to be given to the radiological qualifications of the persons interpreting the x-rays; (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. §718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" set forth in 20 C.F.R. §718.304 and two additional presumptions set forth in §718.305 and §718.306; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon objective medical evidence and supported by a reasoned medical opinion. 20 C.F.R. §718.202(a)(1) - (4) (2002). The U.S. Court of Appeals for the Fourth Circuit (where the instant claim arises) has held that all of the evidence from section 718.202 should be weighed together in determining whether a miner suffers from pneumoconiosis. *See, e.g., Island Creek Coal Co. v. Compton*, 211 F.3d 203, 208-209 (4th Cir. 2000). *But see Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (en banc) (noting "the Sixth Circuit has often approved the independent application of the subsections of Section 718.202(a) to determine whether claimant has established the existence of pneumoconiosis.") Finally, under section 718.107, other medical evidence, and specifically the results of medically acceptable tests or procedures which tend to demonstrate the presence or absence of pneumoconiosis, may be submitted and considered.

X-ray Evidence. The x-ray evidence designated by the parties in the instant claim is summarized in the table below:

Exhibit No.	**Date of X-ray/ Reading**	**Physician/ Qualifications**	**Interpretation**
DX 13 Director's Initial Claimant's Initial	**October 9, 2002** Same	J. Forehand B-reader[7]	Pneumoconiosis, category 1/0, type q/s opacities, upper 2 zones. Quality level 2; "co" (abnormal cardiac size). Comments: "enlarged cardiac silhouette"; enlarged pulmonary artery trunk."
DX 13 (quality only) Director's Initial	October 9, 2002 October 25, 2002	C. Binns BCR, B-reader	Quality level 1; "co" (abnormal cardiac size); "hi" (hilar or mediastinal lymph nodes enlarged). Comments: Rule out congestive heart failure, cardiomegaly, right hilar enlargement.

[7] "B-reader" refers to a B-reader certified by NIOSH and "BCR" refers to a board certified radiologist.

Exhibit No.	Date of X-ray/ Reading	Physician/ Qualifications	Interpretation
EX 3 Employer's Rebuttal	October 9, 2002 August 6, 2004	R.K. Gogineni BCR, B-reader	Negative for pneumoconiosis. Quality level 1; "co" (abnormal cardiac size); "hi" (hilar or mediastinal lymph nodes enlarged).
EX 2 Employer's Initial	**September 16, 2003** Same	K. Hippensteel B-reader	Negative for pneumoconiosis. Quality level 1; "co" (abnormal cardiac size). Comments: "huge central pulmonary arteries"; ectatic aorta.
EX 1 Employer's Initial	**August 4, 2004** August 15, 2004	G. Zaldivar B-reader	Negative for pneumoconiosis. Quality level 2 (Improper positioning/scapula overlay);. "co" (abnormal cardiac size); "em" (emphysema); "hi" (hilar or mediastinal lymph nodes enlarged).

Putting aside the quality interpretation, the October 2, 2002 x-ray was read as positive by one B-reader and as negative for pneumoconiosis by one dually qualified reader;[8] the September 16, 2003 x-ray was read as negative by one B-reader; and the August 4, 2004 x-ray was read as negative by one B-reader. Thus, the x-ray readings preponderate against a finding of pneumoconiosis.

The Benefits Review Board has held that it is proper to accord greater weight to the interpretation of a B-reader or Board-certified Radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and Board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128 (1984).

Taking into consideration the qualifications of the readers, there is only one reading by a dually qualified reader that has been designated by either party and that reading is positive for pneumoconiosis. Thus, the x-ray evidence still preponderates against a finding of pneumoconiosis.

In connection with the instant claim, there was one x-ray reading not designated by any party that is in evidence. That was a September 23, 2004 reading of an x-ray taken the preceding day by Dr. Manu Patel, a dually qualified reader, that is attached to Dr. Rasmussen's examination report. (CX 1). That reading found no classifiable pneumoconiosis, based upon a quality 2 x-ray. *Id.* It is worth noting, however, that Dr. Patel found chronic obstructive

[8] As used herein, a dually qualified reader is a physician who is both a board certified radiologist and a B-reader.

pulmonary disease, bilateral basal minimal scarring, and chronic granulomatous lung changes. *Id.* He recommended a CT scan. *Id.* Inasmuch as that reading found no classifiable pneumoconiosis, it does not assist the Claimant in establishing pneumoconiosis based upon the x-ray evidence.

In connection with the previous claim, there were two readings, both of which were completely negative. A February 13, 1987 x-ray was interpreted by board certified radiologist R. Gale as completely negative, and a February 24, 1987 x-ray was interpreted by B-reader D. Gaziano as completely negative. (DX 1). Those readings, do not, therefore, assist Claimant in establishing pneumoconiosis.

Finally, a panel of the State Occupational Board found pneumoconiosis in 1985 and referenced an x-ray interpretation in doing so. Inasmuch as the x-ray interpretation upon which that determination was based is not of record, and does not appear to have utilized the ILO system or otherwise to have satisfied the regulatory criteria under 20 C.F.R. §718.102, I assign no weight to that determination.

In view of the above, I find that the x-ray evidence weighs against a finding of clinical pneumoconiosis, and I find that Claimant has failed to establish pneumoconiosis based upon the x-ray evidence under section 718.202(a)(1).

Biopsy Evidence. Claimant has failed to establish the presence of the disease under 20 C.F.R. §718.202(a)(2) as there is no biopsy evidence of record.

Complicated Pneumoconiosis and Other Presumptions. A finding of "complicated pneumoconiosis" under 20 C.F.R. §718.304 results in an irrebuttable presumption of total disability. There is no evidence of complicated pneumoconiosis or of opacities that would satisfy the definition of complicated pneumoconiosis. The additional presumptions mentioned in section 718.202(a)(3), which are set forth in 20 C.F.R. §718.305 and 20 C.F.R. §718.306, are also inapplicable, inter alia, because they do not apply to claims filed after January 1, 1982 or June 30, 1982, respectively, and section 718.306 only applies to death claims.

Medical Opinions on Pneumoconiosis. Claimant has also failed to establish the existence of the disease under 20 C.F.R. §718.202(a)(4) based upon the preponderance of the reasoned medical opinion evidence. The following medical opinion evidence has been submitted in connection with the instant claim:

(1) **J. Randolph Forehand, M.D.**, a B-reader who is board certified in allergy and immunology, as well as pediatrics, examined the Claimant for the Department of Labor on October 9, 2002. He reviewed the Claimant's history, clinical test results, and physical findings. He opined that the Claimant had coal workers' pneumoconiosis (based upon the chest x-ray, physical examination, arterial blood gases, and history), cor pulmonale (based upon the EKG, chest x-ray, and physical examination); and chronic bronchitis (based upon the pulmonary function studies.) He attributed the conditions to coal dust exposure and cigarette smoking. He determined that the Claimant had significant respiratory impairment and was totally disabled

from his last coal mining job, and he attributed the impairment to coal workers' pneumoconiosis and its sequela cor pulmonale, with additive effects from cigarette smoking. (DX 13).

(2) **Kirk Hippensteel, M.D.**, a board certified pulmonologist,[9] examined the Claimant for the Employer on September 16, 2003 and he prepared an examination report dated April 20, 2004. He reviewed the Claimant's history, clinical test results, and physical findings. He opined that the Claimant was clearly disabled due to hypoxemia and general health. However, he noted that the Claimant's chest x-ray was not suggestive of coal workers' pneumoconiosis and that he appeared to have significant cardiac dysfunction of unclear etiology. Dr. Hippensteel concluded that the evidence available to him did not implicate coal workers' pneumoconiosis as a cause for Claimant's hypoxemia and general impairment, although they could be of pulmonary origin, and the disabling hypoxemia with pulmonary hypertension could also be caused by cardiac disease. (EX 2).

(3) **George L. Zaldivar, M.D.,** a board-certified pulmonologist, examined the Claimant on August 4, 2004 and prepared an examination report dated October 18, 2004. He reviewed the Claimant's history, clinical test results, and physical findings, and he also reviewed some medical records, which indicated that the Claimant had a history of severe pulmonary hypertension, resolved pulmonary emboli, and chronic obstructive pulmonary disease. A CT scan of the chest taken on December 14, 2001 was reported as showing enlarged central pulmonary arteries consistent with pulmonary artery hypertension but no pulmonary emboli. A CT scan taken at the time of Dr. Zaldivar's examination (discussed below) was interpreted by Dr. Zaldivar and another physician as showing a mass in the right middle or lower lobe (but no evidence of pneumoconiosis.) Based upon a review of all of the evidence, Dr. Zaldivar opined that the Claimant was totally disabled from a pulmonary standpoint due to pulmonary hypertension, resulting from primary pulmonary hypertension and pulmonary emboli; that he may have some degree of emphysema with an asthmatic component resulting from cigarette smoking; that the pulmonary hypertension was not caused by emphysema; that his primary problem was restriction of vital capacity; that coal worker's pneumoconiosis causes an obstructive and not a restrictive impairment; and that the Claimant had low diffusion capacity resulting from the pulmonary hypertension. Dr. Zaldivar opined that the Claimant did not have any impairment resulting from his occupation as a coal miner and that he did not have coal workers' pneumoconiosis or any dust disease of the lungs. (EX 1).

(4) **Donald L. Rasmussen, M.D.,** a pulmonary medicine specialist,[10] examined the Claimant on behalf of the Claimant on September 22, 2004. He reviewed the Claimant's history, clinical test results, and physical findings. He noted that the chest x-ray interpreted by Dr. Patel noted no classifiable pneumoconiosis, as well as other findings (discussed above). He determined that the studies showed very severe, totally disabling respiratory insufficiency that would prevent the Claimant from performing his last regular coal mine job. Dr. Rasmussen noted that the Claimant had a significant history of exposure to coal mine dust but that he had no x-ray changes consistent with pneumoconiosis and a clinical diagnosis of coal worker's

[9] As used herein, "board certified pulmonologist" means a physician who is board certified in internal medicine and the subspecialty of pulmonary diseases.

[10] Dr. Rasmussen is board certified in internal medicine but not in the subspecialty of pulmonary diseases. However, his extensive experience is primarily in the area of pulmonary medicine.

pneumoconiosis could not be made. However, he opined that the causes of the Claimant's disabling lung disease appeared to be his cigarette smoking and his coal mine dust exposure, noting that the x-ray was an imperfect tool and may fail to reveal the presence of even significant pneumoconiosis. He determined that the Claimant's coal mine dust exposure was a significant contributing factor to his disabling lung disease. (CX 1).

In addition to the above, **M. I. Ranavaya, M.D.** examined the Claimant for the Department of Labor on February 13, 1987 in connection with his initial claim. He found obstructive lung disease which could have been caused by a number of factors, including coal mine dust and cigarette smoking. (DX 1). His opinion is too speculative and remote in time to be entitled to any weight.

Factors to be considered when evaluating medical opinions include the reasoning employed by the physicians and the physicians' credentials. *See Millburn Colliery Co. v. Hicks***,** 138 F.3d 524, 536 (4th Cir. 1998). A doctor's opinion that is both reasoned and documented, and is supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *See Fields v. Island Creek Coal Co.,* 10 BLR 1-19, 1-22 (BRB 1987) (stating that a "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis, and that a "reasoned" opinion is one in which the underlying documentation is adequate to support the physician's conclusions). A doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (including both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than a physician who bases a diagnosis on a test or two and one encounter. *See Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In addition, the new regulation appearing at 20 C.F.R. §718.104(d) allows additional weight to be given to the opinion of a treating physician but requires certain factors, including the nature and duration of the relationship, the frequency of treatment, and the extent of treatment, to be considered.

Based upon the credentials of the physicians, I find that the physicians expressing opinions are equally qualified to express opinions. Thus, I will assess the opinions based upon the persuasiveness of their analysis, taking into consideration the extent to which the opinions are documented and reasoned.

Turning first to the issue of "clinical pneumoconiosis" (e.g., CWP or silicosis), only Dr. Forehand diagnosed clinical pneumoconiosis (in the form of coal worker's pneumoconiosis), and he did so in part based upon his reading of the x-ray taken at the time of his examination. However, the weight of the x-ray evidence is clearly against a finding of clinical pneumoconiosis, thereby undermining his opinion. Moreover, Drs. Rasmussen, Hippensteel, and Zaldivar did not find clinical pneumoconiosis. The weight of the medical opinion evidence is therefore against a finding of clinical pneumoconiosis.

Turning to the issue of whether the Claimant has "legal pneumoconiosis," I find that the medical opinion evidence does not support a finding of a lung condition that would fit within that definition either. Notably, in amending the regulations, the Department of Labor discussed the strong epidemiological evidence supporting an association between coal dust exposure and

obstructive pulmonary disability (65 Fed. Reg. 79937-79945 (Dec. 20, 2000)), but it nevertheless chose to require that each individual claimant establish by a preponderance of the evidence that such an association occurred in that individual's case. *Id.* at 79938. Although there is evidence of bronchitis, emphysema, and COPD, I find that Claimant has not established that they were caused or contributed to by coal dust exposure. Dr. Forehand did not squarely address the issue, but to the extent that he may have attributed the Claimant's lung conditions (and specifically, bronchitis) to coal dust exposure, he did so on a conclusory basis. Dr. Rasmussen's opinion is more clear, but, while he has identified factors that generally support an association between coal dust exposure and COPD, he has not pointed to specific factors in this case supporting such an association, as required by the regulations. Dr. Hippensteel reached the opposite conclusion, but his opinion was also stated with some uncertainty and he wanted additional data to sort out the causation issues. Only Dr. Zaldivar obtained a complete picture of the Claimant's pulmonary condition and, while he too expressed some uncertainty as to what was causing the symptomatology, he provided a cogent explanation for his conclusion that it was unrelated to coal mine dust exposure. The other reviewing physicians lacked the amount of evidence concerning the Claimant's medical history that Dr. Zaldivar obtained and considered. I find Dr. Zaldivar's analysis to be the best reasoned and best documented. Based upon consideration of the medical opinion evidence, I find that it preponderates against a finding of a respiratory impairment caused in whole or in part by coal mine dust exposure and therefore Claimant has failed to establish "legal pneumoconiosis."

Other Evidence on Pneumoconiosis. The only other evidence on the issue of the existence of pneumoconiosis consists of the CT scan evidence. The results of a CT scan of December 14, 2001 in the hospital records were summarized by Dr. Zaldivar, as discussed above. In addition, a CT Scan of the chest without contrast was taken at the time of Dr. Zaldivar's August 4, 2004 examination. The radiologist, John A. Willis, M.D., reached the following "Impression":

> Emphysema.
>
> Findings do not suggest occupational pneumoconiosis on the current scans.
>
> Right middle lobe nodule of nonspecific appearance and additional evaluation to exclude pulmonary neoplasm is suggested.
>
> Evidence of previous granulomatous disease including right upper lobe granuloma which is calcified and right hilar calcifications.
>
> Hepatic enlargement with abdominal ascites.

(EX 1). Dr. Zaldivar interpreted this CT scan as showing a large heart, no free fluids, no evidence of nodules of pneumoconiosis, scattered bullae, densities that may be oxygen tubing, and a small uncalcified mass measuring about 1 cm. which may represent a tumor. *Id.* Thus, the CT scan evidence does not support a finding of pneumoconiosis.

All Evidence on Pneumoconiosis. Taking into consideration all of the evidence, I find that the weight of the evidence is against a finding of pneumoconiosis. In this regard, the x-ray and CT scan findings, considered along with the medical opinion evidence, including Dr. Zaldivar's comprehensive opinion, preponderate against a finding of either clinical or legal pneumoconiosis.

Conclusion

Although the evidence supports a finding that the Claimant was totally disabled prior to his death, warranting a reopening of this claim, the evidence does not support a finding of pneumoconiosis. The establishment of pneumoconiosis is an essential element of a claim for black lung benefits. Thus, the claim must be denied and a separate discussion and analysis of the remaining issues raised in this claim is unnecessary.

ORDER

IT IS HEREBY ORDERED that the claim of Lovella Leonard, on behalf of Charles L. Leonard, deceased, for Black Lung Benefits under the Act is **DENIED.**

A

PAMELA LAKES WOOD
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to the Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).